UMASS MEMORIAL HEALTH

# AUTHORIZATION TO DISCLOSE STUDENT PROTECTED HEALTH INFORMATION

**BY UMASS MEMORIAL MEDICAL CENTER - STUDENT HEALTH SERVICES**

HealthAlliance-Clinton Hospital
Marlborough Hospital
UMass Memorial Health - Harrington Hospital
UMass Memorial Medical Center
UMass Memorial Medical Group | Location: ___________________________

NAME:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

HAR / CSN ACCOUNT NUMBER:

PRINT CLEARLY IN INK OR APPLY PATIENT LABEL

I, ____________________________________________________________________________, hereby authorize **UMass Memorial Medical Center ● Student Health Services** (Student Health Services), its employees and/or agents to release the following protected health information that it currently has or may have in the future: Immunization Information (which may include titer results), Tuberculosis Clearance, History and Physical Exam Records (including lab reports and diagnostic test results that I have provided to Student Health Services), and Chest X-Rays.

I authorize the release of this information to: any of the clinical/rotation site(s) of the UMass Chan Medical School (UMCMS), Tan Chingfen Graduate School of Nursing, and Morningside Graduate School of Biomedical Science (collectively referred to in this authorization as UMCMS/TCGSN/MGSBS) and non-UMCMS affiliated clinical/rotation site(s) that I am or will be assigned to as a student of UMCMS/TCGSN/MGSBS, the Clinical and/or Rotation Coordinators for UMCMS/TCGSN/MGSBS, the UMCMS/TCGSN/MGSBS Clerkship Directors, the UMCMS/TCGSN/MGSBS Travel Coordinators, and the designated UMCMS/TCGSN/MGSBS school representatives for compliance.

The purpose of this authorization is to allow for the sharing of information to verify that I meet all communicable disease clearance requirements. I understand that if I do not authorize this information to be provided to clinical or rotation sites, the site may refuse to allow me to rotate within their facility.

This authorization will expire when I am no longer a student at UMCMS/TCGSN/MGSBS, unless I revoke it before such time.
I have the right to revoke this authorization at any time by submitting this request in writing to Student Health Services by email to studenthealth@umassmemorial.org.

I understand this authozation is voluntary, and I do not need to sign it to receive treatment.

I understand any disclosure carries the potential for unauthorized re-disclosure. I release UMass Memorial Health and its entities from any legal liability that may arise from the disclosure or re-disclosure of this information.

I have read an understand the above statements and authorize the disclosures requested in this form.

| ______________________ | ______________________ | __________ | __________ |
|---|---|---|---|
| Student Signature | Printed Name | Date | Time |

***Please submit this completed form to Student Health Services via Peoplesoft Portal.***